Physical Therapy Services of Morristown, LLC

Name:_______________________________ **Age**:________ **Acct. #**:___________

In order for us to provide a thorough evaluation, please answer the following questions regarding your medical history. Place a check the box to the left of the item. Your therapist will assist you if you have any difficulty.

Please check any of the following conditions you may have or had:

	Anemia		Epilepsy or Seizure		Multiple Sclerosis
	Arthritis / Osteoporosis		Fractures		Neurological Condition
	Asthma		Heart Condition		Prostate problems
	Cancer		Hepatitis		Rheumatoid Arthritis
	Chemical Dependency		High Blood Pressure		Skin Conditions
	Circulation Problems		High Cholesterol		Stroke
	Complicated Pregnancy		Kidney Disease		Thyroid Condition
	Diabetes		Low Blood Sugar		Tuberculosis
	Emphysema / Bronchitis		Lymes Disease		Ulcers/Stomach Problems
	Endometriosis		Mental Illness / Depression		Visual Impairments

Other/Comments:

Has anyone in your immediate family ever been diagnosed with any of the following?

	Arthritis / Osteoporosis		Heart Condition		Mental Illness
	Cancer		High Blood Pressure		Stroke
	Chemical Dependency		High Cholesterol		
	Diabetes		Kidney Disease		

Other/Comments:

Within the past year, have you had any of the following tests?

	Angiogram		CT Scan		MRI
	Biopsy		Doppler Ultrasound		Stress Test
	Blood Test		Echocardiogram		Urine Test
	Bone Scan		Mammogram		X Rays

Other/Comments:

Have you recently noted?

	Fatigue		Numbness / Tingling		Weight Gain
	Fever, Chills, Sweats		Weakness		Weight Loss

Other/Comments:

Please check any of the following healthcare providers who are currently providing you care, or have provided you care in the past six (6) months:

	Acupuncturist		Homeopath		Physical Therapist
	Chiropractor		Massage Therapist		Psychiatrist / Psychologist
	Dentist		Medical Doctor		

Other/Comments:

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List and describe any surgeries or hospitalizations that you have had:

List any injuries that you have had which required medical attention:

List all prescription and non-prescription medications you are currently taking:

Are you, or do you think that you may be pregnant? YES NO
Do you have any religious beliefs that might affect your care? YES NO
If you were to lose consciousness under our care,
would you object to lifesaving measures being performed
to resuscitate you? (I.e. CPR) YES NO
Are you allergic or sensitive to latex? YES NO
Are you allergic to shellfish or iodine? YES NO

Other Allergies:

Do you smoke cigarettes now? YES NO
Quantify:___________(packs p/day) How long have you been smoking?___________________

Have you smoked in the past? YES NO
When did you quit?______________ How long had you been smoking?____________________

Do you drink alcohol? YES NO
Quantify:___________(drinks p/day)

Do you drink caffeine? YES NO
Quantify:___________(drinks p/day)

Have you recently been feeling depressed, down or helpless? YES NO
Have you recently had little interest or pleasure in doing things? YES NO
Do you feel unsafe at home or is someone trying to injure you? YES NO

____ ____________________
Signature of Patient or Guarantor Date

____ ____________________
Signature of Therapist Date